CHAPTER IV: INPATIENT REHABILITATION FACILITY PPS PAYMENT CALCULATIONS

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CHAPTER IV:

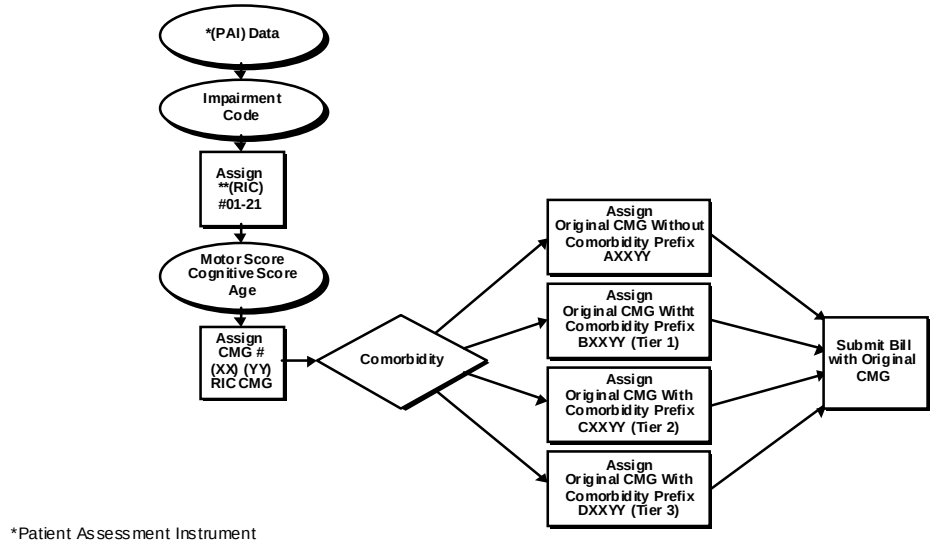
IRF PPS Payment Calculations

OBJECTIVE

The objective of this chapter is to provide participants with an understanding of the inpatient rehabilitation facility prospective payment system (IRF PPS) payment provisions. At the end of this session, participants will obtain an understanding of:

- The phase-in period for IRF PPS.
- How case-mix groups (CMGs) are developed.
- The computation of federal CMG payment rates using the budget neutral conversion factor published in the *Federal Register.*
- The calculation of case-level adjustments specific to the CMG.
- The calculation of facility-level adjustments.
- Pass-through payments.
- Anticipated effect of IRF PPS on the remittance advice, PS&R reporting and cost reporting.

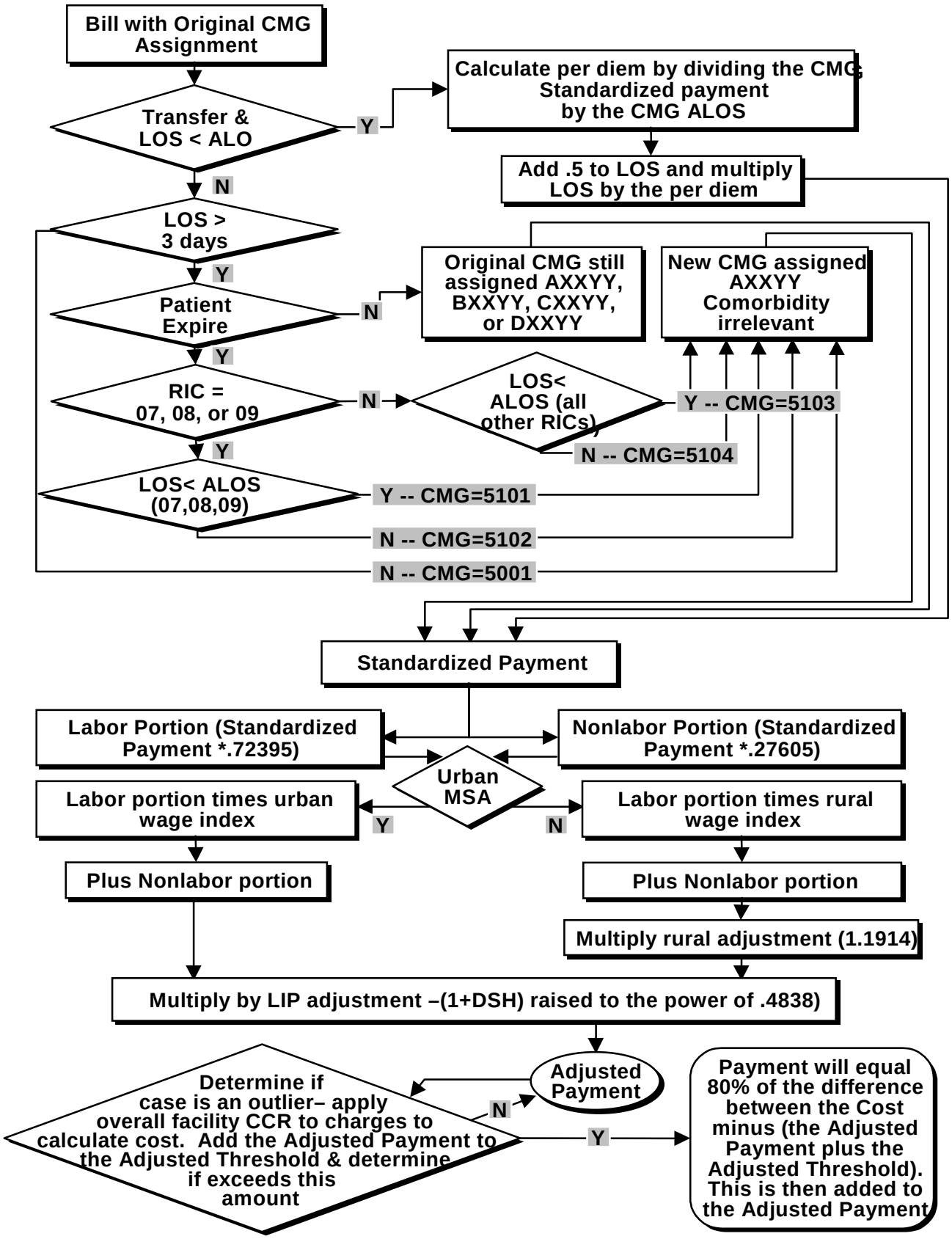
IRF PPS Flow Chart



*Patient Assessment Instrument

**Rehabilitation Impairments Categories

1


Bill with Original CMG Assignment
Transfer & LOS < ALO
Y
Calculate per diem by dividing the CMG Standardized payment by the CMG ALOS
Add .5 to LOS and multiply LOS by the per diem
N
LOS > 3 days
Y
Patient Expire
N
Original CMG still assigned AXXYY, BXXYY, CXXYY, or DXXYY
New CMG assigned AXXYY Comorbidity irrelevant
Y
RIC = 07, 08, or 09
N
LOS< ALOS (all other RICs)
Y -- CMG=5103
N -- CMG=5104
Y
LOS< ALOS (07,08,09)
Y -- CMG=5101
N -- CMG=5102
N -- CMG=5001
Standardized Payment
Labor Portion (Standardized Payment *.72395)
Nonlabor Portion (Standardized Payment *.27605)
Urban MSA
Labor portion times urban wage index
Y
N
Labor portion times rural wage index
Plus Nonlabor portion
Plus Nonlabor portion
Multiply rural adjustment (1.1914)
Multiply by LIP adjustment –(1+DSH) raised to the power of .4838)
Adjusted Payment
Determine if case is an outlier– apply overall facility CCR to charges to calculate cost. Add the Adjusted Payment to the Adjusted Threshold & determine if exceeds this amount
N
Y
Payment will equal 80% of the difference between the Cost minus (the Adjusted Payment plus the Adjusted Threshold). This is then added to the Adjusted Payment

Phase-In Implementation

- **Cost Reporting Periods Beginning on or after January 1. 2002 and Before Oct. 1, 2002**
- **Paid 66 2/3% PPS and 33 1/3% TEFRA**
- **May Elect 100% PPS**

BIPA 2000 - Election of 100% PPS

- **IRF must notify intermediary no later than thirty days prior to its first cost reporting period for IRF PPS**

Full Implementation

- **All Cost Reporting Periods Beginning on or after October 1, 2002**
- **Paid 100% PPS**

PHASE-IN IMPLEMENTATION

Under the BBA, the federal fiscal year in which a facility's cost reporting period begins, determines which transition period percentages apply. The first transition period percentages were to be applicable for cost reporting periods beginning during federal fiscal year 2001, that is, periods beginning on or after October 1, 2000, and before October 1, 2001. The second transition period percentages were to be applicable to cost reporting periods beginning during federal fiscal year 2002, that is, periods beginning on or after October 1, 2001, and before October 1, 2002. For cost reporting periods beginning during federal fiscal year 2003 and after, payment is based on 100 percent of the adjusted federal prospective payment.

As the IRF PPS is being implemented for cost reporting periods beginning on or after January 1, 2002, IRFs will be phased directly into the second transition period, where payment will be based on 66 percent of the PPS payment and 33 1/3 percent of the TEFRA payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its entire cost reporting period beginning prior to January 1, 2002.

In addition, Section 305 of the BIPA 2000 states facilities may elect to be paid 100 percent PPS payment, rather than payment based on the transition method. If a facility chooses not to be paid under the transition method, it must notify its FI no later than thirty days prior to its first cost reporting period for which the IRF PPS applies to the facility. The request to make the election must be made in writing to the FI for the facility. The FI must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period falls on a day that the postal service or other delivery sources are not open for business,

the facility is responsible for allowing sufficient time for delivery of the request before the deadline. If a facility's request is not received or not approved, payment will be based on the transition method.

MEDICARE PATIENT ASSESSMENT INSTRUMENT

Patient Assessment Instrument

- **Beginning 1/1/2002 for Medicare Part A FFS Patients**
- **At Admission and Discharge**
- **Software Provided to Facilities**

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients.

Beginning on January 1, 2002, for Medicare Part A fee-for-service patients, IRFs must collect patient assessment data using the CMS IRF patient assessment instrument (PAI) as part of the IRF's inpatient assessment process. This data collection requirement applies to Medicare beneficiaries who are already inpatients as of January 1, 2002, as well as beneficiaries admitted as inpatients on or after January 1, 2002. The IRFs must encode the patient assessment data by entering the data into a computer software program that will be provided at no charge to IRFs. The CMS web site has information regarding the computer software program.

Patient Assessment Instrument

- **Admission PAI used to Classify Patient into CMG**
- **Discharge PAI used to Determine Comorbidities**

Assessment Schedule and PAI Guide to be Provided

The admission patient assessment will be used to classify each Medicare Part A fee-for-service patient into a CMG, and the CMG will be used to determine the IRF payment. While the admission assessment is used to place a patient in a CMG, the discharge assessment is used to determine the relevant weighting factors, if applicable, associated with comorbidities.

The final rule contains detailed information regarding the assessment schedule for the PAI with respect to transmission requirements, encoding dates, and other pertinent information. CMS will provide a guide, which will include detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Case-Mix Groups

- **Rehabilitation Impairment Categories**
- **Motor/Cognitive/ Age**
  (Table 1)

Comorbidities
- **Three Tiers**
- **(Appendix C)**

CASE MIX GROUP CLASSIFICATION SYSTEM

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. The Final Rule used 21 Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are formed using codes from the International Classification of Diseases 9th Revision-Clinical Modification codes (ICD-9-CM codes). In addition to the RICs, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age also allowed CMS to improve the explanatory power of the CMGs by splitting some of the groups based on the age variable.

Comorbidity Tiers

- **Tier 1 (High Cost)**
- **Tier 2 (Medium Cost)**
- **Tier 3 (Low Cost)**
- **No Comorbidities**

Comorbidities

CMGs were further split by the presence of certain comorbidities using a tiered approach. Comorbidities were found to substantially increase the average cost of specific CMGs. The comorbidities are arrayed in three tiers based on whether the costs are considered high, medium, low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

Comorbidities - Extract from Appendix C

Appendix C--List of Comorbidities (Abbreviated)

ICD-9 Code		Tier 1	Tier 2	Tier 3	Excluded RIC
112.4.....	CANDIDIASIS OF LUNG.....	1	0	0	15
112.5.....	DISSEMINATED CANDIDIASIS.....	1	0	0	.....
112.81....	CANDIDAL ENDOCARDITIS.....	1	0	0	14
112.83....	CANDIDAL MENINGITIS.....	1	0	0	03, 05
011.02....	TB LUNG INFILTR-EXM UNKN.....	0	1	0	15
011.03....	TB LUNG INFILTR-MICRO DX.....	0	1	0	15
011.04....	TB LUNG INFILTR-CULT DX.....	0	1	0	15
011.05....	TB LUNG INFILTR-HISTO DX.....	0	1	0	15
013.23....	TUBRCLOMA BRAIN-MICRO DX.....	0	1	0	3
013.24....	TUBRCLOMA BRAIN-CULT DX.....	0	1	0	3
013.25....	TUBRCLOMA BRAIN-HISTO DX.....	0	1	0	3
093.20....	SYPHIL ENDOCARDITIS NOS.....	0	0	1	14
093.82....	SYPHILITIC MYOCARDITIS.....	0	0	1	14
094.87....	SYPH RUPT CEREB ANEURYSM.....	0	0	1	01, 03
130.3.....	TOXOPLASMA MYOCARDITIS.....	0	0	1	14
130.4.....	TOXOPLASMA PNEUMONITIS.....	0	0	1	15
136.3.....	PNEUMOCYSTOSIS.....	0	0	1	15
204.00....	ACT LYM LEUK W/O RMSION.....	0	0	1	.....

CMG Categories

- **100 CMG Categories**
- **95 CMGs Separated by RIC Motor Scores and Possibly By Cognitive Scores and Age.**
- **Five Additional CMGs Created to Account for Atypical Cases**

CMG CATEGORIES

The final rule includes 100 CMG categories. Rehabilitation Impairment Category motor scores and possibly cognitive scores and age separate 95 CMGs. Five additional CMGs were created to account for atypical cases.

FIVE ADDITIONAL CMG CATEGORIES

Five additional CMG categories were created for the following special situations:

- Short stay cases with fewer than three days, but the case is not a transfer.

- Two categories for cases where expired orthopedic patients have a length of stay greater than three days
  - One category for greater than three days up to the average length of stay.
  - One category for stays longer than the average length of stay.

- Two categories for cases where expired non-orthopedic patients have a length of stay greater than three days
  - One category for greater than three days up to the average length of stay.
  - One category for stays longer than the average length of stay

CMG Relative Weights Basis:

- **Costs from FY 96-98 Cost Reports**
- **Charges from CY 99 Bill Data**
- **Excluded All-inclusive Providers**
- **Relative Weights Account for Variances in Cost Per Discharge Among CMGs**

CMG RELATIVE WEIGHTS

Relative weights were calculated using cost report data from fiscal year 1998, 1997 and 1996, charge data was obtained from calendar year 1999 Medicare bill data, and functional measures were derived from the FIM data. Data was omitted from rehabilitation facilities that are classified as all-inclusive providers from the calculation of the relative weights, because these facilities are paid a single, negotiated rate per discharge and they do not maintain a charge structure. Calculated relative weights were further adjusted to reflect the comorbidity tiers identified in the final rule. A listing of the 100 CMGs and the appropriate case-mix weights has been published in the final rule (Table 1).

100 Distinct CMG Payment Categories

- **Standard Payment Amount/Budget Neutral Conversion Factor**
- **Relative Payment Weights**
- **Neutralized for Facility Level and Case Level Adjustments**

PAYMENT RATES

The IRF prospective payment system utilizes federal prospective payment rates across 100 distinct CMGs. The federal payment rates are established using a standard payment amount (referred to as the budget neutral conversion factor). A set of relative payment weights that account for the relative difference in resource use across the CMGs is applied to the budget neutral conversion factor and, finally, a number of facility-level and case-level adjustments may apply. The facility-level adjustments include those that account for geographic variation in wages (wage index), percentages of low-income patients (LIPs), and location in a rural area. Case-level adjustments include those that apply for interrupted stays, transfer cases, short stays, cases in which patients expire, and outlier cases.

Budget Neutral Conversion Factor

Budget Neutral Conversion Factor is $11,838.00

- **Costs from FY 96-98 Cost Reports**
- **Charges from CY 98 and 99 Bill Data**
- **Used Data From 1,024 Facilities**

The BBA specifies that payments during fiscal years FY 2001 and 2002 must be established in a manner that results in the amount of total payments, including any adjustments, being equal to 98 percent of the amount of payments that would have been made during those fiscal years (for operating and capital costs) had the IRF PPS not been enacted. However, as a result of the implementation of BIPA, a change has been made to eliminate the payment amount of 98 percent of the FY 2002 expenditures. Under section 305 of the BIPA 2000, section1886 (j)(3)(b) of the Act is amended to increase the amount of payment to 100 percent of FY 2002 expenditures.

The budget neutral conversion factor was determined using costs from FY 96-98 cost reports, and charges from calendar year 98 and 99 billing data, CMS used data from 1,024 facilities to determine the budget neutral conversion factor of $11,838.00.

SAMPLE CALCULATION OF CMG PAYMENT RATE

CMG Weight Multiplied by Budget Neutral Conversion Factor = CMG Payment Rate

The final rule includes a listing of the relative weights for CMGs in Table 1 and a listing of CMG payment rates in Table 2. An extract of Tables 1 and 2 is shown on the following page.

- In our example, the patient has a stroke and is assessed with a motor score of 34-38. Patient is 82 years old or younger with no comorbidities.

  Since the patient cannot be classified into one of the comorbidity tiers, the first character of the HIPPS code will be A.

  The next four characters equal the CMG from the assessment, which in this case is 0109.

  The HIPPS Code billed would be A0109.

The case-mix adjusted prospective rate would be computed as follows:

Computation of Case-Mix Prospective Payment Amount		
1	Weight for CMG A0109 (no comorbidity) From Table 1 of final rule.	1.5265
2	Budget neutral conversion factor	$11,838.00
3	Calculated case-mix adjusted prospective payment rate (line 1 x line 2) From Table 2 of final rule.	$ 18,070.71

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Federal CMG Payments

- **8/7/2001 Federal Register**
- **Updates to be Published Prior to August 1 of Preceding Year**

For the initial period of PPS, beginning on or after Jan. 1, 2002, all payment rates and associated rules were published in the *Federal Register* on Aug. 7, 2001. For each succeeding FY, the rates will be published in the *Federal Register* on or before August 1 of the year preceding the affected FY.

Payment Rates - Extract from Tables 1 and 2

Table 1.--Relative Weights for Case-Mix Groups (CMGs)

CMG	CMG Description (M=Motor, C=Cognitive, A-Age)	Relative Weights				Average Length of Stay				Payment Rates			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	No Comorbidities
0101..	Stroke; M=69-84 and C=23-35.	0.4778	0.4279	0.4078	0.3859	10	9	6	8	$5,656.20	$5,065.48	$4,827.54	$4,568.28
0102..	Stroke; M=59-68 and C=23-35.	0.6506	0.5827	0.5553	0.5255	11	12	10	10	7,701.80	6,898.00	6,573.64	6,220.87
0103..	Stroke; M=59-84 and C=5-22.	0.8296	0.743	0.708	0.67	14	12	12	12	9,820.80	8,795.63	8,381.30	7,931.46
0104..	Stroke; M=53-58.....	0.9007	0.8067	0.7687	0.7275	17	13	12	13	10,662.49	9,549.71	9,099.87	8,612.15
0105..	Stroke; M=47-52.....	1.1339	1.0155	0.9677	0.9158	16	17	15	15	13,423.11	12,021.49	11,455.63	10,841.24
0106..	Stroke; M=42-46.....	1.3951	1.2494	1.1905	1.1267	18	18	18	18	16,515.19	14,790.40	14,093.14	13,337.87
0107..	Stroke; M=39-41.....	1.6159	1.4472	1.379	1.305	17	20	21	21	19,129.02	17,131.95	16,324.60	15,448.59
0108..	Stroke; M=34-38 and A;83.	1.7477	1.5653	1.4915	1.4115	25	27	22	23	20,689.27	18,530.02	17,656.38	16,709.34
0109..	Stroke; M=34-38 and A:82.	1.8901	1.6928	1.613	1.5265	24	24	22	24	22,375.00	20,039.37	19,094.69	18,070.71
0110..	Stroke; M=12-33 and A;89.	2.0275	1.8159	1.7303	1.6375	29	25	27	26	24,001.55	21,496.62	20,483.29	19,384.73
0111..	Stroke; M=27-33 and A=82-88.	2.0889	1.8709	1.7827	1.6871	29	26	24	27	24,728.40	22,147.71	21,103.60	19,971.89
0112..	Stroke; M=12-26 and A=82-88.	2.4782	2.2195	2.1149	2.0015	40	33	30	31	29,336.93	26,274.44	25,036.19	23,693.76
0113..	Stroke; M=27-33 and A:81.	2.2375	2.004	1.9095	1.8071	30	27	27	28	26,487.53	23,723.35	22,604.66	21,392.45
0114..	Stroke; M=12-26 and A:81.	2.7302	2.4452	2.33	2.205	37	34	32	33	32,320.11	28,946.28	27,582.54	26,102.79
0201..	Traumatic brain injury; M=52-84 and C=24-35.	0.7689	0.7276	0.6724	0.617	13	14	14	11	9,102.24	8,613.33	7,959.87	7,304.05

Payment Adjustments

Payment Adjustments

- **Two Types**
  - **Case Level**
  - **Facility Level**

Both case level and facility level adjustments may be applied to federal prospective payment amounts. Case level adjustments include interrupted stays and transfers. Facility level adjustments include adjustments to account for geographic area wage variations, adjustments for facilities located in rural areas and adjustments to reflect the percentage of low-income patients.

After all case and facility adjustments have been applied. Outlier payments will be made for those cases whose estimated costs exceed a threshold.

Federal CMG Prospective Payments

CASE-LEVEL ADJUSTMENTS

Payment will be based on the CMGs described above, as well as possible adjustments specific to the case and the facility characteristics. More than one case level adjustment may apply to the same case. Thus, for ease of understanding we present the discussion of the case-level adjustments in the same order that will be used to assess whether or not they apply. For instance, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

Interrupted Stays

Interrupted Stay

- **Discharged and Returns to Same Facility By Midnight of the Third Day Following Discharge**
- **LOS Includes Days Prior to Interruption and Days After**
- **Payment Based on Initial Assessment**

Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within three consecutive calendar days. The three consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption. One CMG payment will be made for cases in which the patient's stay was interrupted. The payment will be based on the initial assessment.

Example - In our earlier example, the patient has a stroke and is assessed with a motor score of 34-38. Patient is 82 years old or younger with no comorbidities. Lets assume that the patient was discharged April 2, 2002, and was readmitted on April 4, 2002 (an interruption of 2 calendar days).

The HIPPS Code billed would be A0109. The HIPPS code would still be based on the initial assessment.

Transfer Cases

Transfer Cases

- **Transferred and LOS less than Average LOS for CMG**
- **Per-Diem Payment**
- **First Day Receives Additional ½ Payment**

For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient acute care hospital, or a nursing home that accepts payment under either the Medicare program or the Medicaid program AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Transfer cases will be paid on a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition

of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

Example – Using data from our previous example, the patient has a stroke and is assessed with a motor score of 34-38. Patient is 82 years old or younger with no comorbidities. Let's assume that the patient was transferred to an inpatient hospital setting on day 13 and was not readmitted within three days.

The HIPPS Code billed would be A0109.

Computation of Transfer Payment Amount		
1	Payment for CMG A0109 (no comorbidity) From Table 2 of final rule.	$18,070.71
2	ALOS for CMG A0109	24 Days
3	Calculate unadjusted per diem amount (Line 1 divided by line 2)	$752.95
4	Number of days in IRF prior to transfer plus one-half day adjustment	12.5
5	Transfer payment amount	$9,411.88

Short Stay Cases

- **LOS less than 3 Days**
- **Separate CMG Payment**
- **Includes Expired Cases Within 3 Days**

Expired Cases LOS Greater than 3 Days

- **Separate CMG Payments**
- **4 CMG Groups**

Short-Stay Cases

The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of three days or less, without consideration of the clinical characteristics of the patient. Further cases that expire with a length of stay of three days or less will also be classified to CMG 5001.

Expired Cases

Separate CMGs will also be made for cases that expire with a length of stay greater than three days. To improve the explanatory power of the groups, CMS created four additional CMGs to account for cases that expire. CMG 5101 will be used for short-stay, orthopedic, expired cases. This CMG includes those cases that would otherwise be grouped to RICs 07, 08, and 09, and the length of the stay is greater than three days, but less than or equal to 13 days. CMG 5102 will be used for orthopedic expired cases where the length of stay is greater than or equal to 14 days. CMG 5103 will be used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than three days, but less than or equal to 15 days. CMG 5104 will be used for non-orthopedic expired cases where the length of stay is greater than or equal to16 days.

FACILITY-LEVEL ADJUSTMENTS

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for facilities located in rural areas, and an adjustment for treating low-income patients. Outlier payments will also be discussed in this section. Although outlier payments are

considered to be a case-level adjustment, a case can only be determined to qualify for these additional payments after all other facility-level adjustments are computed. Thus, for ease of understanding we present the discussion of these facility-level and outlier adjustments in the same order that will be used to assess their applicability.

Area Wage Adjustment

- **Labor Related Portion 72.395%**
- **Inpatient Acute Care Hospital Wage Data**
- **Excludes Teaching Physicians, I&R and CRNAs**
- **Excludes Geographic Reclassifications**

Area Wage Adjustment

To adjust payments for area wage differences, the excluded hospital market basket with capital costs was analyzed to identify the labor-related portion of the prospective payment rates. The labor-related portion has been determined to be 72.395 percent and the non-labor related portion is 27.605 percent. The labor-related unadjusted federal payment is multiplied by a wage index value to account for area wage differences. The inpatient acute care hospital wage data will be used to compute the wage indices. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare Part B, because these services are not covered under the IRF PPS. The wage index that will apply to the IRF PPS payment rates excludes 100 percent of wages for teaching physicians, residents, and nonphysician anesthetists.

IRFs are divided into labor market areas. As with other CMS payment systems, urban areas are defined as a Metropolitan Statistical Areas (MSAs) or New England County Metropolitan Areas, as defined by the Executive Office of Management and Budget. For the purposes of computing the wage index for IRFs, the wage index values for urban and rural areas are determined without regard to geographic reclassification.

Example – Using data from our previous example, the patient has a stroke and is assessed with a motor score of 34-38. Patient is 82 years old or younger with no comorbidities. Lets assume that the patient was not transferred. The HIPPS Code billed was A0109 and the unadjusted payment rate was $18,070.71.

The services for our example were provided by an IRF located in Rural City, Arkansas. Rural City has wage index of .7444.

The case-mix adjusted prospective rate will be adjusted for the wage index as follows:

Wage Index Adjustment to Prospective Payment Amount		
1	Prospective payment rate for CMG A0109 (from above)	$ 18,070.71
2	Labor percentage of prospective Payment Rate	0.72395
3	Labor portion of prospective Payment Rate (line 1 x line 2)	$ 13,082.29
4	Wage index factor	.7444
5	Wage adjusted labor portion of prospective payment rate (line 3 x line 4)	$ 9.738.46
6	Non-labor portion of prospective payment rate (line 1 less line 3)	$4988.42
7	Total adjusted prospective payment rate (line 5 + line 6)	$ 14,726.88

Adjustments for Rural Location

Payments will also be adjusted for facilities located in rural areas. A facility will be considered to be a rural IRF if it is located in a non-MSA area. Payments to rural IRF will be multiplied by 1.1914.

Example - Using our sample payment data from above.

Rural Adjustment Calculation		
1	Total wage adjusted prospective payment rate (from above)	$ 14, 726.88
2	Rural adjustment	1.1914
3	Rural adjusted prospective payment rate	$ 17,545.61

Low Income Patient Adjustment

- **All Hospitals Eligible for Adjustment**
- **Based on DSH Calculation Methodology**

Low Income Patients

Additional payments will be made for treating low income patients (LIP). There are two parts in computing this adjustment. The first is the calculation of the disproportionate share variable (DSH). This is computed by:

Note: The measure to determine the percentage of low-income patients used to calculate the LIP adjustment will be DSH, which also is used to measure the percentage for acute care hospitals. As described in the final rule, for IRF units the DSH measure will be based on the experience of the IRF distinct part unit. CMS will provide instructions in the future describing in detail where these measures can be obtained. CMS's web site (HCFA.gov/Medicare/IRFPPS.HTM) will contain the latest available information.

Sample Calculation of DSH Percentage		
DSH =	SSI Days / Total Medicare Days +	Medicaid, Non-Medicare Days / Total Days
	66 / 510 +	110 / 844
25.97%	12.94% +	13.03%

Once the DSH is calculated, this percentage is used to determine the LIP adjustment. Each IRF payment will be multiplied by the following formula to account for the cost of furnishing care to low income patients:

[1+DSH] raised to the power of .4838
[1 +25.97%] raised to the power of .4838 = 1.1182

Sample LIP Adjustment Calculation		
1	Rural adjusted prospective payment rate (from above)	$ 17,545.60
2	LIP adjustment	1.1182
3	LIP adjusted prospective payment rate (line 1 times 2)	$19,619.49

Cost Outliers

Additional payments will be made for those cases that are high cost outliers. A case will be considered to be an outlier if the estimated cost of the case exceeds an adjusted threshold amount. The estimated cost of the case will be calculated by multiplying the charge by the facility's overall cost-to-charge ratio obtained from the latest settled cost report. If the estimated cost of the case is greater than the sum of the adjusted payment amount and the adjusted threshold amount, then the case is considered an outlier and additional payments will be added to the adjusted payment amount. The outlier payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the facility-level adjusted CMG payment and the threshold amount multiplied by the facility-level adjustments as described above). The fixed loss unadjusted threshold amount as determined in the final rule is $11,211.

Outlier Adjustments
- **Made for Those Cases Where Estimated Costs Exceed a Threshold Amount**
- **Payment will be 80 Percent of Amount the Cost Exceeds the Sum of the Adjusted Threshold Amount and the Adjusted Payment**

Note: CMS will provide instructions regarding the cost-to-charge ratio that will be used in the calculation of outlier payments. CMS's web site will contain the latest available information.

Adjusted Outlier Threshold Amount

- **Final Rule Loss Threshold Amount of $11,211.00**
- **Loss Threshold Adjusted for Case and Facility Adjustments**
- **Includes Adjusted Prospective Payments Amounts For CMG**

Outlier payments are determined in the following manner:

- Calculate estimated cost of case by applying cost-to-charge ratio to covered charge.
- Calculate the case adjusted and facility adjusted prospective payment rate.
- Calculate the case adjusted and facility adjusted loss threshold amount.
- Add the adjusted prospective rate for CMG to adjusted loss amount.
- Subtract the threshold sum of the previous step amount from estimated cost of the case and apply 80 percent to the difference to determine outlier adjustment.

Sample Outlier Calculations

Note: All calculations will be performed automatically by the IRF PPS Pricer program)

To assist in understanding the outlier payment concept, we will work through a computation using the sample provider data from earlier in the chapter. Required data includes:

- Covered charges applicable to CMG A0109 are $26,000
- IRF cost-to-charge ratio is 1.2555
- CMG case adjusted and facility adjusted prospective payment for CMG 0109 is $19,619.49
- IRF PPS Wage Index is .7444
- Rural Adjustment is 1.1914
- LIP Adjustment is 1.118220

Step 1 - Calculate Estimated Cost of Case

1. Covered charge for CMG 0109	$26,000
2. IRF cost-to-charge ratio	1.2555
3. Total estimated cost of case (line 1 times 2)	$32,643.00

Step 2 - Calculate Adjusted Loss Threshold Amount

4. Loss threshold amount:	$11,211.00
5. Wage adjust labor portion of outlier amount: Multiply loss threshold amount of $11,211.00 times labor percentage .72395 = $8,116.20 multiply times wage index .7444 = $6041.70	$6,041.70
6. Determine non-labor portion of loss threshold amount: Loss threshold amount of $11,211.00 minus labor portion of $8,116.20 equals $3,094.80	$3,094.80
7. Wage adjusted loss threshold amount (line 5 plus 6)	$9,136.50
8. Rural adjustment percentage	1.1914
9. Rural adjusted loss threshold	$10,885.23
10. LIP adjustment percentage	1.118220
11. Loss threshold adjusted for case and facility adjustments (line 9 times 10)	$12,172.08

Step 3 -Calculation of Outlier Payment

12. Total estimated cost of case (from line 3)	$32,643.00
13. Loss threshold adjusted for case and facility adjustments (from line 11)	$12,172.08
14. Adjusted prospective payments for case (CMG A0109)	$19,619.49
15. Adjusted outlier threshold amount (line 13 plus 14)	$31791.57
16. Amount over outlier threshold line12 minus15)	$851.43
17. **Outlier Payment** (line 16 times 80%)	$681.14
18. **Total Payments to Provider*** (line 14 plus 17)	$20,300.63

*During the transition period IRFs will receive 662/3 percent of the PPS interim payment plus 33/1/3 percent of the TEFRA payment unless the IRF elects to receive 100 percent PPS payments.

PASS-THROUGH PAYMENTS

Pass-Through Payments

- **Bad Debts**
- **Approved Education Programs**
- **Blood Clotting Factors**

Part A Medicare bad debts, costs of an approved educational program and blood clotting factors provided to Medicare inpatients who have hemophilia are paid outside of the IRF PPS.

INTERIM PAYMENTS TO PROVIDERS

PIP Payments Continued

Outlier Payments Excluded From PIP

IRF PPS does not preclude the continuation of PIP. For those services paid under the PIP method, the amount reflects the estimated prospective payments for the year rather than estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in section 412.632 and receives approval by its FI. Similarly, if an FI determines that an IRF that received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in section 412.632, FI approval of a PIP is conditioned upon the FI's best judgment as to whether making payment under the PIP method would not entail undue risk of resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the IRF prospective payment system, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions of the existing regulations at section 413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method, it may qualify to receive an accelerated payment. Under section 412.632, the IRF must be experiencing financial difficulties due to a delay by the FI in making payment to the IRF, or there is a temporary delay in the IRF's preparation and submittal of bills to the FI beyond its normal billing cycle because of an exceptional situation. The IRF must make a request for an accelerated payment, which is subject to approval by the FI and by CMS. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment occurs as bills are processed or through direct payment by the IRF.

IRF PPS OVERLAP BILLS

IRF PPS Overlap Bills

- **Split Billing Eliminated**
- **Interim Bills Must Be Cancelled**

In situations where a beneficiary's stay overlaps the time in which IRF PPS applies to the facility, the PPS payment will be based on the discharge. A facility will not be allowed to spilt bill for services that overlap the start of its fiscal year subject to IRF PPS.

Facilities will be required to submit adjustment bills for interim bills previously submitted for services overlapping the start of its fiscal year subject to IRF PPS.

REMITTANCE ADVICES

Remittance Advices

- **ERA Version 3051.4a.01 will Have CMG Level Reporting**
- **No CMG On Earlier ERA Versions or Paper Remittance**

A new remittance advice remark code (N100, PPS code corrected during adjudication) has been developed to notify an IRF when the CMG code has been changed.

FIs will continue to use existing remittance advice notices for IRF PPS services. Facilities that use version 3051.4A.01 of the electronic remittance advice (ERA) will receive CMG level detail. The ERA will reflect the actual CMG code used for payment.

Facilities that use earlier versions of the ERA or that receive the standard paper remittance advice will not receive CMG level detail reporting.

ANTICIPATED CHANGES TO THE PS&R SUMMARY REPORTS

A new IRF Pricer program has been developed to calculate IRF PPS interim payments. The new Pricer program will make the following information available to the PS&R system:

MSA
Wage Index
Average LOS
Relative Weight
Total Payment Amount
PPS Federal Payment Amount
Facility Specific Payment Amount
Outlier Payment Amount
Low Income Payment (LIP) Percentage
LOS Regular Days Used
Life Time Reserve Days Used
Transfer Percentage
Facility Specific Rate (prior to blend)
Standard Payment Amount
PPS Federal Payment Amount (prior to blend)
Facility Costs
Outlier Threshold
Submitted HIPPS/CMG Code
PPS Pricer CMG Code
Calculation Version Code

The PS&R will be modified to produce detail and summary reports that will capture most of the above data. The PS&R reports will continue to reflect data currently shown, such as discharge and days.

ANTICIPATED COST REPORTING CHANGES

The hospital cost report, Form CMS-2552-96, will be revised for cost reporting periods beginning on or after January 1, 2002. At a minimum, the following changes will be required:

- Worksheet S-2, will need to be revised to provide for the election of payment based on 100 percent of the federal IRF PPS amounts.

- Worksheet E-3, Part I, will need to be revised to separately identify payments net of LIP and outlier amounts.

- LIP payments will have to be recomputed at the cost report year-end based on federal payments net of outlier amounts.

- For cost reporting periods beginning on or after January 1, 2002, and before October 1, 2002, the 33 1/3 TEFRA and 66 2/3 PPS blended payment will be computed on Worksheet E-3, Part I.